STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN9401	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the complaint investigation of #39308, #39320, and #39486, conducted on 8/22/16 to 9/6/16, at Claiborne and Hughes Health Center, no deficiencies were cited related to the complaints under 1200-8-6, Standards for Nursing Homes. Complaint #39308 was substantiated with a deficiency cited unrelated to complaint. Complaints #39320 and #39486 were not substantiated.	N 000		
N 410	1200-8-6-.04(5) Administration (5) The facility shall make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss. A record shall be prepared of all clothing, personal possessions and money brought by the resident to the nursing home at the time of admission. The record shall be filled out in duplicate. One copy of the record shall be given to the resident or the resident's representative and the original shall be maintained in the nursing home record. This record shall be updated as additional personal property is brought to the facility. This Rule is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to obtain a personal inventory upon admission for 2 (Resident #2, 8) of 9 records reviewed. The findings included: Review of the facility policy "Personal Property" revised 12/2009, revealed "...The resident's personal belongings and clothing shall be	N 410	N410 The facility will make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss. A record will be prepared of all clothing, personal possessions and money brought by the resident to the nursing home at the time of admission. The record will be filled out in duplicate. One copy of the record shall be given to the resident or the resident's representative and the original will be maintained in the nursing home record. This will be updated as additional personal property is brought to the facility.	

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N 410	Continued From page 1 inventoried and documented upon admission and as such items are replenished..." Medical record review for Resident #2 revealed admission to the facility on 6/24/16 with diagnoses including Chronic Kidney Disease Stage 3, Coronary Artery Disease, Diabetes Mellitus, Psychosis, and Dementia. Observation on 8/22/16 at 9:05 AM and 12:28 PM revealed Resident #2 had personal clothing and personal items in her room. Medical record review revealed no Inventory of Personal Effects form in the medical record. Interview with the Administrator, on 8/22/16 at 4:50 PM in the administrative lobby, confirmed the facility failed to complete the personal inventory upon admission. Medical record review for Resident #8 revealed admission to the facility (from his home) on 8/5/16 with diagnoses including Depression, Neuromuscular Dysfunction of Bladder, Diabetes Mellitus Type 2, Obsessive-Compulsive Disorder, Conductive Hearing Loss, History of Venous Thrombosis and Embolism, Benign Prostate Hypertrophy, and Insomnia. Medical record review revealed the Inventory of Personal Effects form was not filled out regarding Resident #8's personal property brought to the facility at time of admission. Interview with the Director of Nursing on 8/25/16 at 12:18 PM in the Business Office Manager (BOM) office, confirmed the facility failed to follow the policy to complete the inventory form at admission.	N 410	Corrective Action 1. A personal inventory log was completed for resident #2 on 8/22/16. Resident #9 had already discharged from facility. 2. An audit was started on 8/22/16 for all residents to ensure a personal inventory log is completed on all residents personal items. 3. An in-service was started by the DON on 10/3/16 for all staff regarding the completion of an inventory log for all residents upon admission to include who is responsible, proper Labeling of items and adding to the inventory log as needed. 4. All new admission inventory logs will be reviewed by the Admissions coordinator weekly to ensure compliance. Results will be reviewed in the monthly QA/PI.	10/20/16

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N 410	Continued From page 2 Interview with the Admission Coordinator, on 8/25/16 at 3:20 PM in the BOM office, stated she escorted the responsible party and Resident #8 to his room and the responsible party had a laundry basket with multiple personal hygiene items and a small amount of personal clothing for Resident #8 that the responsible party left in the room. Interview with Licensed Practical Nurse #1, on 8/25/16 at 4:05 PM in the BOM office, confirmed he was the admission nurse for Resident #8. Further interview revealed the resident arrived with personal clothing.	N 410		